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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KANANIONAPUA L. SIMMONS** 6560 SE Mabel Avenue Portland, OR 97267 Registered Nurse License No. 626175 Respondent.	Case No. 2011-864 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (Board).

2. On or about September 16, 2003, the Board issued Registered Nurse License No. 626175 to Kananionapua L. Simmons (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2011, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 118, subdivision (b), provides that the suspension, expiration, surrender or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 provides that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

"(b) Procuring his or her certificate or license by fraud, misrepresentation, or mistake.

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

"(e) Making or giving any false statement or information in connection with the application for issuance of a certificate or license. . . ."

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7. Section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022. . . ."

8. Section 2764 provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), the Board may renew an expired license at any time within eight (8) years after the expiration.

REGULATORY PROVISIONS

9. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

10. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

11. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16, section 1442, on the grounds of unprofessional conduct, in that on or about August 11, 2008, Respondent committed acts of gross negligence, repeated failures of extreme departures from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Respondent was on duty as a registered nurse at Sierra Vista Regional Medical Center (Sierra Vista), Labor and Delivery Unit, San Luis Obispo, California, and assigned as the labor and delivery nurse to care for a 37 year-old full-term pregnancy female (the patient). Respondent treated the patient who was in labor and administered Oxytocin/Pitocin[1] outside of hospital protocol by administering an excessive dose of Oxytocin/Pitocin and in shorter duration than policy guidelines, as follows:

12. Respondent as the labor and delivery nurse assigned to the patient was to administer Oxytocin/Pitocin while assessing contraction frequency, duration and strength.

13. On or about August 11, 2008, at 2200 hours, Respondent transcribed the patient's attending physician's medication orders to the record: "Restart Pitocin per protocol."

14. Sierra Vista's protocols, in pertinent part, are as follows:

a. Administration of Oxytocin/Pitocin for augmentation

"increases of only 1-2 mu/minute"

"increase at 15 – 30 minute intervals"

"Pitocin may be restarted with MD order at 50-60% of the rate when it was stopped, if signs of fetal distress abate"

b. Re-evaluating dosage of Oxytocin/Pitocin

"tachycardia – FHR baseline > 160"

"uterine contraction strength of > 90 mm/Hg" (when not pushing)

[1] Oxytocin is a naturally produced hormone secreted in bursts to induce contractions. Pitocin is a synthetic form of Oxytocin used to induce labor or to augment (speed up) labor.

c. Indications for discontinuing Oxytocin/Pitocin administration

"Persistent late or severe variable decelerations"

d. Documentation

"IV Pitocin documented on IV profile

"uterine contraction strength, duration, frequency and resting tone recorded at the start of the infusing and with each dose increase"

"maternal blood pressure and pulse recorded with each increase in Pitocin"

15. On or about August 11, 2008, on the patient's labor and delivery specific form, Intrapartum Flow Sheet, during the time period of 1200 – 2300 hours, on the Medication administration section and line for Pitocin, Respondent documented "4~6-8-off" and did not properly allocate specifics as instructed on the form: "Pitocin mu/min | Time | ↑,↓,dose,off".

16. On or about August 11, 2008, from a compilation of hospital records for the patient, the patient's Oxytocin/Pitocin administration versus the rate and time per Sierra Vista's protocols is as follows:

Time Block	Time Recorded	Pitocin Rate Administered	Pitocin Rate per Protocol
1700-1730	1740	off	ok
1730-1800	1740	1mu	ok
1800-1830	1820	2mu	ok
1830-1900	1859	off	ok
1900-2200	3 hours	off	ok
2200-2215	2215	4mu	1mu
2215-2230	2220	6mu	2-3mu
2230-2245	2230/2235	8mu	3-5mu
2245-2300	2254	off	n/a
2300-2315	-	off	n/a
2315-2330	2322	Baby Delivered	

17. On or between 2130 and 2230, a review of the fetal monitor strip records the fetus' baseline fetal heart rate's variability/accelerations and decelerations during patient contractions were as follows:

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Time Block	Baseline FHR	Variablity / Accelerations	Decelarations	Contraction Frequency	Contraction Strength	Oxytocin Rate
2130-2200	160-170	Minimum-Moderate No accels.	Recurrent variable deceleration with slow return to baseline	2 in 10 min	65-90	off
2200-2215	160-170 180 at end	Moderate No accels.	Recurrent variable deceleration with slow return to baseline	2 - 3 in 10 min	60-95	4mu/min
2215-2230	170 150 unclear	Moderate Rare possible acceleration	Recurrent variable deceleration with slow return to baseline. Some decelrations long, unclear of type.	3 in 10 min	60-65 unclear due to pushing	6 mu/min
2230-2245	155-165	Moderate No accels.	Variable with slow return to baseline. Deeper and longer.	4 in 10 min	One appears to be over 100mm/Hg without pushing	8 mu/min
2245-2254	170	Moderate	Variable with slow return to baseline deeper and longer, erratic at end	3 in 10 min	Three 95 to over 100 mm/Hg without pushing	8 mu/min
2253					Loss of pressure noted in catheter inside uterus	
2254 - 2256	FHR drops from 180 to 70					off
2301	70-75					off

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18. On or about August 11, 2008, at 2322 hours, the patient gave birth to a liveborn male infant, 8 pounds 9 ounces, 3880 grams and 21 ¼ inches long, via emergency cesarean delivery.

19. Respondent deviated from the Standard of Practice as follows:

a. Respondent restarted administration of Oxytocin/Pitocin to the patient at 4 mu/minute instead of 1 mu/minute as called for in the hospital policy.

b. Respondent increased the administration of Oxytocin/Pitocin to the patient more frequently than every 15 minutes as called for in the hospital policy.

c. Respondent administered Oxytocin/Pitocin to the patient for augmentation when the fetal heart rate (FHR) pattern was non-reassuring during the time period of 2130 to 2253. Respondent failed to stop the Oxytocin infusion when fetal tachycardia persisted and worsened.

d. Respondent failed to assess the uterine contraction pattern or maternal vital signs with every increase of Oxytocin/Pitocin as called for in the hospital policy.

SECOND CAUSE FOR DISCIPLINE

(Out-of-State Discipline)

20. Respondent is subject to disciplinary action under section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that on or about June 23, 2000, Respondent was disciplined by the State of New Mexico, Board of Nursing (BON). On or about June 23, 2000, in the administrative matter entitled *In the Matter of: Kananionaua Simmons, License No. R44459*, the BON issued a Decision and Order placing Respondent on probation for one (1) year under the condition that she agrees to abstain from alcohol and any and all illicit drugs. The basis for discipline was that on or about August 20, 1999, Respondent submitted a urine drug screen at Lovelace Park Center that tested positive for marijuana. The Decision and Order is attached hereto as Exhibit A and incorporated herein by reference.

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THIRD CAUSE FOR DISCIPLINE

(Unlawful Use / Self-Administration of a Controlled Substance)

21. Respondent is subject to disciplinary action under section 2761, subdivision (a), and 2762, subdivision (a), on the grounds of unprofessional conduct, in that on or about August 20, 1999, Respondent tested positive for marijuana, without a valid prescription. Complainant refers to and by this reference incorporates the allegations set forth above in paragraph 20, inclusive, as though set forth fully.

FOURTH CAUSE FOR DISCIPLINE

(False Statement on License Application)

22. Respondent is subject to disciplinary action under section 2761, subdivision (e), in that on or about August 13, 2003, under penalty of perjury that all information provided is true, correct and complete on her Application for RN Licensure by Endorsement, Respondent falsely answered "No" to question No. 16(f) asking "Have you ever . . . had disciplinary proceedings against any license as an RN or any health-care related license including revocation, suspension, probation, voluntary surrender, or any other proceeding?" On or about June 23, 2000, Respondent sustained discipline against her RN license by the State of New Mexico's Board of Nursing. Complainant refers to and by this reference incorporates the allegations set forth above in paragraph 20, inclusive, as though set forth fully.

FIFTH CAUSE FOR DISCIPLINE

(Procured License by Fraud, Misrepresentation, or Mistake)

23. Respondent is subject to disciplinary action under section 2761, subdivision (b), in that Respondent procured her license by fraud, misrepresentation, or mistake when, in contrary to the truth, on or about August 13, 2003, she attested to the Board that she had not sustained any discipline against any registered nurse license she possessed. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 22-23, inclusive, as though set forth fully.

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SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct / Violate Nursing Practice Act)

24. Respondent is subject to disciplinary action under sections 2761, subdivisions (a) and / or (d), in that Respondent committed acts of unprofessional conduct and / or violation so the Nursing Practice Act. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 11-23, inclusive, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 626175, issued to Kananionapua L. Simmons;

2. Ordering Kananionapua L. Simmons to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/19/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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EXHIBIT A

State of New Mexico, Board of Nursing Decision and Order, dated June 23, 2000

BEFORE THE BOARD OF NURSING
FOR THE STATE OF NEW MEXICO

IN THE MATTER OF:
Kananionapua Simmons
LICENSE NO: R44459

RESPONDENT.

I certify this to be a true copy of the records on file with the New Mexico Board of Nursing.
Signed:

DECISION AND ORDER

This matter having come before the New Mexico Board of Nursing ("BON") and a quorum being present and a majority voting in the affirmative, the BON finds as follow:

FINDINGS

1. The Respondent is licensed under the Nursing Practice Act, §61-3-1 et seq. N.M.S.A., and is subject to the jurisdiction of the BON.
2. Respondent submitted a urine drug screen at Lovelace Park Center on August 20, 1999. The screen was positive for marijuana.

CONCLUSIONS

The BON is authorized to revoke, suspend, reprimand or place on probation the Respondent's license for violations of §61-3-28 N.M.S.A. 1978.

ORDER

It is therefore ordered that Respondent's license is:

☐ Revoked

☐ Suspended for _____.

☒ Placed on probation for 1 year under the following conditions:

a. That she agrees to abstain from alcohol and any and all illicit drugs.

b.

c.

☐ Reprimanded

6-23-00
DATE

Christine Glidden

CHRISTINE GLIDDEN, ACTING CHARIPERSON
NEW MEXICO BOARD OF NURSING

Any person entitled to a hearing under the Uniform Licensing Act [61-1-1 to 61-1-31 NMSA 1978], who is aggrieved by an adverse decision of a board issued after hearing, may obtain a review of the decision in the district court of Santa Fe county or in the district court of the county in which the hearing was held or, upon agreement of the parties to the appeal, in any other district court of the state. In order to obtain such review, the person shall, within twenty days after the date of service of the decision as required by Section 61-1-14 NMSA 1978, file with the court a petition for review, a copy of which shall be served on the office of the attorney general and on the board secretary, stating all exceptions taken to the decision and indicating the court in which the appeal is to be heard. The court shall not consider any exceptions not stated in the petition. Failure to file a petition for review in the manner and within in the time stated shall operate as a waiver of the right to judicial review and shall result in the decision of the board becoming final; except that for good cause shown, within the time stated, the judge of the district court may issue an order granting one extension of time not to exceed sixty days.

CERTIFIED MAIL NO: 2 4052 67916
RETURN RECEIPT REQUESTED